A. INTRODUCTION

Covered services are those described in HSS 107.13 (2) and 107.13(3), Wis. Admin. Code, when delivered by providers certified in accordance with HSS 105.22 (for psychotherapy providers) and HSS 105.23 (for Alcohol and Other Drug Abuse [AODA] providers), Wis. Admin. Code. Please refer to Appendix 3 of this handbook for a complete list of allowable procedure codes for mental health and AODA services, along with information on which psychotherapy and AODA providers may bill each procedure code, limitations which apply to the procedure codes, and allowable diagnoses.

B. COVERED PSYCHOTHERAPY SERVICES

Requirements for Psychotherapy Services

Recordkeeping and General Requirements

The following recordkeeping and general requirements are outlined in HSS 61.97 (11) - (15) Wis. Admin. Code.

An initial assessment must be performed by staff to establish a diagnosis on which a preliminary treatment plan is based, which shall include but is not limited to:

- the recipient's presenting problems with the onset and course of symptoms, past treatment response, and current manifestation of the presenting problems;
- preliminary diagnosis; and
- personal and medical history.

A treatment plan must be developed with the recipient upon completion of the diagnosis and evaluation.

Progress notes must be written in the recipient's clinical record. The notes shall contain status and activity information about the recipient that relates to the treatment plan. Progress notes are to be completed and signed by the therapist performing the therapy session.

A discharge summary containing a synopsis of treatment given, progress and reasons for discharge shall be written in the recipient's clinical record when services are terminated.

All recipient clinical information received by the provider shall be kept in the recipient's clinical record. The following requirements must be met:

- recipient records must be stored in a safe and secure manner;
- policy must be developed to determine the disposition of recipient clinical records in the event of closing;
- a written policy governing the disposal of recipient clinical records must be developed;
- recipient clinical records must be kept at least five years;
- upon termination of a staff member, the recipient clinical records for which he or she is responsible must remain in the custody of the clinic where the recipient was receiving services unless the recipient requests, in writing, that the records be transferred; and
- upon written request of the recipient, the provider must transfer the clinical information required for further treatment as determined by the supervising physician or psychologist.

Based on reviews of recipient records, the WMAP believes that recordkeeping can be enhanced by the following good practices:

B. COVERED PSYCHOTHERAPY SERVICES (continued)

- including information in the assessment on previous treatment history and outcome, making sure the assessment materials support the diagnosis made, and updating assessment materials as new information becomes available;
- including both short-term and long-term measurable goals in the treatment plan; and
- including information in the discharge summary on the provider's response to non-compliance, including efforts to engage the recipient in treatment, when this was a factor in discontinuing treatment. Also, identify how a return to treatment might be most easily handled.

Refer to Section IV of Part A of the WMAP Provider Handbook for further information regarding recordkeeping.

Outpatient psychotherapy services are a covered benefit when provided under the following conditions:

1. treatment is provided in accordance with the definition of psychotherapy;

   Psychotherapy is defined in HSS 101.03(145) Wis. Admin. Code, as "the treatment of an individual who is mentally ill or has medically significant emotional or social dysfunctions by a psychotherapy provider. The treatment is a planned and structured program based on information from a differential diagnostic examination and directed at the accomplishment of specified goals. The treatment goals may include removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behavior, and promoting positive personal growth and development by enhancing the ability to adapt and cope with internal and external stresses."

2. a differential diagnostic examination is performed by a certified psychotherapy provider. A physician's prescription is not required to perform the examination. Any WMAP certified psychotherapy provider may perform the differential diagnostic examination;

   A differential diagnostic examination is defined in HSS 101.03(42), Wis. Admin. Code, as "an examination and assessment of a recipient's emotional and social functioning which includes one or more of the following: neurological studies, psychological tests and psycho-social assessments."

3. before the actual provision of psychotherapy services, a physician (this need not be a psychiatrist) prescribes the therapy in writing. Prescriptions must include the length of time that services are expected to be required. The length of time may be up to one year. New prescriptions are required after one year; and

4. the provider who performs psychotherapy is certified by the WMAP as a psychotherapy provider as described in Section I-B of this handbook and engages in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed.

Psychiatric Evaluation and Diagnostic Testing

Up to six hours of face-to-face psychiatric evaluation or diagnostic testing during a two year period may be provided without prior authorization. Time spent scoring and interpreting diagnostic tests and writing up the results of the evaluation are allowable parts of diagnostic

B. COVERED PSYCHOTHERAPY SERVICES (continued)

testing. These six hours do not count towards the 15 hours or $500 prior authorization threshold for psychotherapy/AODA services. Evaluation and testing services provided to a recipient by any certified psychotherapy provider count toward the two year evaluation threshold.

Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

When evaluation services by any combination of psychotherapy providers exceed six hours in a two-year period, the provider may seek prior authorization for the evaluation. Psychiatric evaluation and diagnostic testing in excess of six hours in a two-year period must be prior authorized to be paid as a psychiatric evaluation. Refer to Section III of this handbook for information on requesting prior authorization for psychiatric evaluation and testing.

Psychiatric evaluations in excess of six hours in a two-year period that do not have prior authorization are denied and may be rebilled as limitation exceeded psychotherapy, or if the limit was exceeded because the services were provided by more than one provider, backdating of the prior authorization request may be allowed. Refer to Section III-G of this handbook for information on backdating prior authorization requests. Psychiatric evaluations and diagnostic testing services are not subject to a diagnosis restriction and do not require a referring/prescribing provider.

Allowable psychiatric evaluations and diagnostic testing services include:

1. the initial differential diagnostic examination;
2. assessments necessitated by changes in the individual's behavior, environment, physical or psychological condition which are required to determine whether changes need to be made in the recipient's treatment plan;
3. assessments or evaluations which are performed with the recipient as a part of supervisory oversight;
4. time spent in face-to-face contact with a recipient as part of a consultation requested by the primary psychotherapy provider;
5. psychiatric evaluations which are required pursuant to legal proceedings to determine an individual's mental competency, if the recipient is not incarcerated at the time of the evaluation;
6. evaluations or assessments which are performed on children or adolescents pursuant to legal proceedings to determine the necessity for out-of-home placement; and
7. court appearances to defend against commitment.

Neuropsychological testing is considered a neurological service and is not subject to the policy described in this handbook. Procedure codes for neuropsychological testing may be billed by physicians or psychologists. Services are billed in one hour units. Refer to Appendix 18 of this handbook for information about which procedure codes may be billed for neuropsychological testing.

Evaluation techniques and instruments are to include those which are accepted as the standard of practice (e.g., psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook). The provider must have training in the use of the particular instrument being employed.

B. **COVERED PSYCHOTHERAPY SERVICES** (continued)

Limitation-Exceeded Psychotherapy

Limitation-exceeded psychotherapy is used to bill allowable psychiatric evaluation and diagnostic testing services when any combination of providers has exceeded the six hour per two-year limit when evaluation services have not been prior authorized. The limitation-exceeded psychotherapy procedure codes, like psychiatric evaluations, are not subject to a diagnosis restriction and do not require a referring/prescribing provider. However, they do count toward the 15 hour/$500 yearly prior authorization threshold for psychotherapy/AODA services and are denied if this threshold has been exceeded and the provider does not have prior authorization. Refer to Section III of this handbook for information on requesting prior authorization for evaluations and diagnostic testing.

Services by a psychiatrist or psychologist provided at the inpatient hospital setting and separately billed as a professional service are not subject to prior authorization.

Individual Psychotherapy

Individual psychotherapy is covered when it meets the requirements for psychotherapy services listed above. Specialized forms of individual treatment, such as narcosynthesis, hypnotherapy, medical psychoanalysis, and biofeedback, should be performed by providers who have specific training and experience in the use of these techniques and should be billed using the appropriate procedure codes listed in Appendix 3 of this handbook. Providers should refer to Appendix 3 of this handbook for information on who may bill for these procedures and limitations that may apply. Only one provider may bill for a particular treatment session.

Family Psychotherapy

Family psychotherapy is covered for the recipient, the recipient's immediate family member(s), and the recipient's significant others. Immediate family members include parents, foster parents, spouse, children, or foster children. The recipient who is the identified mental health client must be present in the group in order for the session to be billed as family psychotherapy. Such a session may involve more than one recipient, but only one provider may bill for one recipient for a particular treatment session. No more than two providers may bill for the same family psychotherapy session.

Family psychotherapy without the recipient present is also covered for members of the recipient's immediate family as defined in the previous paragraph and must be billed under the procedure code for "Family Medical Psychotherapy (without recipient present)."

Group Psychotherapy

Group psychotherapy is defined as a session in which more than one but not more than ten individuals (they do not all need to be WMAP recipients) receive psychotherapy services together from one or two providers. The recipient who is the identified mental health client must be present in the group in order for the session to be billed. No more than two providers may be reimbursed for the same session, and they may not claim reimbursement for the same recipients in the group.

Multiple family group psychotherapy is covered for the recipient and members of the recipient's immediate family. The immediate family includes the recipient's spouse, parents, foster parents, children, or foster children. The recipient who is the identified mental health client must be present in the group in order for the session to be billed.

Group psychotherapy is considered a hospital service when provided to an inpatient and may not be separately billed as a professional service by any professional discipline.

B. COVERED PSYCHOTHERAPY SERVICES (continued)

Emergency Psychotherapy
Emergency psychotherapy may be performed by a provider for a recipient even if the required prescription for treatment or prior authorization has not been obtained prior to the provision of care when the provider has reason to believe that the recipient is an immediate threat to him/herself or others. A prescription for the emergency treatment must be obtained within 48 hours of the time the emergency treatment was provided, excluding weekends and holidays. Emergency psychotherapy requires prior authorization before payment is made if the recipient has exceeded the 15 hour/$500 limit for services in a calendar year. Refer to Section III of this handbook for information on requesting prior authorization.

Chemotherapy Management (Medication Check)
Chemotherapy management is a covered service when provided by a physician or a registered nurse. Chemotherapy management includes the prescription, directions on the use of, and review of medication, with no more than minimal psychotherapy. When physicians or registered nurses provide chemotherapy management, they may also administer the medication.

Chemotherapy management is considered a hospital service when provided to hospital inpatients and may not be separately billed as a professional service.

Collateral Interviews
Collateral interviews (sessions where the recipient is not present) are covered services for immediate family members only. Immediate family members include the recipient's parents, spouse, children, children in foster care, and foster parents. Collateral interviews are billed using the Medical Assistance identification number of the recipient who is the identified mental health client. Refer to Appendix 3 of this handbook for information on who may bill this service and any limitations that may apply.

Electroconvulsive Therapy
Electroconvulsive therapy is a covered service when provided by a psychiatrist. This service is not subject to the psychotherapy prior authorization requirements.

C. COVERED AODA TREATMENT SERVICES

Requirements for AODA Treatment Services

Recordkeeping and General Requirements
The following recordkeeping requirements are taken from HSS 61.52(5)-(12), Wis. Admin. Code.

There shall be a case record for each recipient and contact register for all service inquiries.

The case recordkeeping format shall provide for consistency, facilitate information retrieval, and shall include the following:

1. Consent for treatment forms signed by the recipient.
2. Acknowledgement of program policies and procedures which is signed and dated by the recipient.
3. Reports from referring sources.
4. Results of all examinations, tests, and other assessment information.
   An assessment shall be done by members of the clinical staff and shall be clearly explained to the recipient and to the recipient's family, when appropriate, and must include the following:

C. COVERED AODA TREATMENT SERVICES
(continued)

- identification of the alcohol or drug abused, frequency and duration of use, method of administration and relationship to the recipient's dysfunction, and
- available information on the recipient's family, legal, social, vocational, and educational history.

5. Treatment plans
Based on the assessment made of the recipient's needs, a written treatment plan shall be developed and recorded in the recipient's case record.

A preliminary treatment plan shall be developed as soon as possible, but not later than five working days after the recipient's admission.

Treatment may begin before completion of the plan.

The plan shall be developed with the recipient, and the recipient's participation in the development of treatment goals shall be documented.

The plan shall specify the services needed to meet the recipient's needs and attain the agreed upon goals.

The goals shall be developed with both short and long range expectations and written in measurable terms.

The plan shall describe criteria to be met for termination of treatment.

6. Medication records which shall allow for ongoing monitoring of all medications administered and the detection of adverse drug reactions. All medication orders in the recipient case record shall specify the name of the medication, dose, route of administration, frequency of administration, person administrating, and name of the physician who prescribed the medication.

7. Multidisciplinary case conference and consultation notes
Recipient progress and current status in meeting the goals set in the plan shall be reviewed by the recipient's treatment staff at regularly scheduled case conferences.

The date and results of the review and any changes in the treatment plan shall be written into the recipient's record.

The participants in the case conference shall be recorded in the case record.

8. Correspondence including all letters and dated notations of telephone conversations relevant to the recipient's treatment.

8. Correspondence including all letters and dated notations of telephone conversations relevant to the recipient's treatment.

9. Consent for disclosure of information release forms.

10. Progress notes
Progress notes shall be regularly entered into the recipient's case record.

Progress notes shall include the following:

- chronological documentation of treatment given to the recipient which shall be directly related to the treatment plan;

C. COVERED AODA TREATMENT SERVICES (continued)

- documentation of the recipient's response to and the outcome of treatment; and
- progress notes shall be dated and signed by the person making the entry.

11. Record of services provided which shall include summaries sufficiently detailed so that the person not familiar with the program may identify the types of services the recipient has received.

12. Discharge documentation
A discharge summary shall be entered in the recipient's case record within one week after termination of treatment.

The discharge summary shall include:

- a description of the reasons for discharge;
- the recipient's treatment status and condition at discharge;
- a final evaluation of the recipient's progress towards the goals set forth in the treatment plan; and
- a plan developed, in conjunction with the recipient, regarding care after discharge and follow-up.

Based on reviews of recipient records, the WMAP believes that recordkeeping can be enhanced by the following good practices:

- including information in the assessment on previous treatment history and outcome, making sure the assessment materials support the diagnosis made, and updating assessment materials as new information becomes available; and
- including information in the discharge summary on the provider's response to non-compliance, including efforts to engage the recipient in treatment, when this was a factor in discontinuing treatment. Also, identify how a return to treatment might be most easily handled.

Refer to Section IV of Part A of the WMAP Provider Handbook for further information regarding recordkeeping.

Outpatient AODA treatment services are a covered benefit when provided under the following conditions:

1. the treatment services are in accordance with the definition of AODA treatment;

   AODA treatment services are defined in HSS 101.03(13), Wis. Admin. Code, as alcohol and other drug abuse treatment services provided by a certified provider to assist alcoholics and drug abusers and persons affected by problems related to the abuse of alcohol or drugs. Examples of AODA treatment services are client evaluation, orientation and motivation, treatment planning, consultation and referral, client education, individual counseling, group counseling and crisis intervention.

C. COVERED AODA TREATMENT SERVICES (continued)

2. before the enrollment in an AODA treatment program, the recipient must receive a complete medical evaluation by a physician. The medical evaluation must be performed within 60 days prior to the first date of AODA services. The evaluation should include diagnosis, summary of present medical findings, medical history, and explicit recommendations and the prescription by the physician for participation in the alcohol or drug abuse treatment program;

   This medical evaluation is not a differential diagnostic evaluation. Differential diagnostic evaluations are psychiatric evaluations. A medical evaluation is required to determine the recipient's medical conditions which may have a bearing on the suitability of the person for AODA treatment. The medical evaluation does not count toward the 15 hour/$500 psychotherapy prior authorization threshold or toward the six hour per 2 year limit on psychiatric evaluation;

3. the supervising physician or psychologist develops a treatment plan which relates to behavior and personality changes being sought and to the expected outcome of treatment; and

4. the provider who performs alcohol and other drug abuse treatment is certified by the WMAP as an AODA treatment provider as described in Section I-B of this handbook and engages in face-to-face contact with the recipient for at least 5/6 of the time for which reimbursement is claimed under the WMAP Program.

Individual AODA Therapy

Individual AODA therapy is a covered service when it meets the criteria listed in the section on "Requirements for AODA Treatment Services." Providers should refer to Appendix 3 of this handbook for information on who may bill for this service and limitations that may apply. Only one provider may bill for the same treatment session.

Family AODA Therapy

Family AODA therapy is covered for the recipient, the immediate member (or members) of the recipient's family, and the recipient's significant others. Immediate family members include parents, foster parents, spouse, children, or foster children. Such a session may involve more than one recipient, but only one provider may bill for one recipient for the same treatment session. No more than two providers may bill for the same family AODA psychotherapy session.

Group AODA Therapy

Group AODA therapy is defined as a session in which more than one but not more than ten individuals (they do not all need to be WMAP recipients) receive AODA therapy services together from one or two providers. No more than two providers may be reimbursed for the same session, and they may not claim reimbursement for the same recipients in the group.

Treatment of Affected Family Members

Treatment of recipients who are affected family members or significant others of individuals with alcohol and other drug abuse problems is covered as an AODA treatment service when the affected recipient has very recently been involved with an active alcohol or drug abuser and has active treatment issues with the addicted individual, regardless of whether the addicted person is still abusing alcohol or drugs, or is in treatment or recovery. The affected family member receiving treatment services must have an allowable ICD-9-CM diagnosis, as listed in Appendix 3 of this handbook. The affected family member may receive individual, group, or family AODA therapy, and the appropriate AODA procedure code should be billed. Refer to Appendix 3 of this handbook for a list of allowable procedure codes.

C. COVERED AODA TREATMENT SERVICES (continued)

If the affected individual requires treatment for the effects of his/her relationship with an addicted individual, but they no longer are actively involved with that person, the treatment is considered psychotherapy and must be provided by a certified psychotherapist and meet the requirements listed in Section II-B of this handbook.

AODA Intensive Outpatient Treatment

The WMAP covers AODA intensive outpatient treatment at a non-51.42 Board clinic service. Intensive outpatient service consists of a combination of individual, group, and family therapy offered for 4-16 hours per week for 4-16 weeks. Most of this service requires prior authorization. Refer to Section III-B and Appendices 9, 10, and 11 of this handbook for further information on requesting prior authorization for these services.

D. SERVICES PROVIDED TO RECIPIENTS DIAGNOSED AS MENTALLY RETARDED

Psychotherapy or AODA treatment services are not covered for individuals whose primary or only diagnosis is mental retardation (ICD-9-CM diagnoses 317-319). However, the WMAP recognizes that these individuals may have valid mental health or AODA problems distinct from the mental retardation. For purposes of coverage as a WMAP psychotherapy or AODA treatment service, the mental health or AODA diagnosis is considered primary in these situations. In addition to having an allowable ICD-9-CM diagnosis for the procedure billed, the recipient must be able to benefit from the particular treatment provided in order for the service to be reimbursable by the WMAP.

E. HEALTHCHECK "OTHER SERVICES"

The WMAP considers requests for medically necessary mental health/AODA services which are not specifically listed as covered services, or which are listed in this section as noncovered services, when the following conditions are met:

1. the provider verifies that a comprehensive HealthCheck screening has been performed;
2. the service is allowed under the Social Security Act as a "medical service";
3. the service is medically necessary and reasonable to correct or ameliorate a condition or defect which is discovered during a HealthCheck screening;
4. the service is noncovered under the current WMAP state plan; and
5. a service currently covered by the WMAP is not appropriate to treat the identified condition.

All requests for HealthCheck "Other Services" are subject to prior authorization. Refer to Section III-B of this handbook for information on requesting prior authorization.

F. REVIEW OF PSYCHIATRIC AND AODA INPATIENT STAYS

This handbook must be followed by physicians in private practice. Admitting physicians and hospitals are responsible for meeting the requirements in this section.

Prior to elective/urgent admissions and after emergency admissions, the following inpatient hospital stays must be reviewed by the Wisconsin Peer Review Organization (WIPRO):

- all AODA admissions;
- all elective psychiatric admissions; and
- all psychiatric admissions to inpatient hospital programs for individuals under age 21 in an IMD.

F. REVIEW OF PSYCHIATRIC AND AODA INPATIENT STAYS (continued)

This review is to evaluate the medical necessity of inpatient treatment for WMAP payment purposes. WIPRO makes final determinations of medical necessity of admissions that are "suspect" based on a retrospective review of the recipient's medical record. All psychiatric and AODA hospitalizations are subject to retrospective review by WIPRO based on selection criteria established by the WMAP. Providers should contact WIPRO directly at 1-800-833-7247, if there are questions about this review process. Refer to Appendix 22 of this handbook for additional information on the review process.

G. NONCOVERED SERVICES AND RELATED LIMITATIONS

As specified in HSS 107.13(2)(d), Wis. Admin. Code, the following services are not WMAP-covered outpatient psychotherapy clinic services:

- collateral interviews with persons other than the recipient's immediate family (parents, spouse and children, or for children in foster care, foster parents) and consultations, except as provided in HSS 107.06 (4)(c), Wis. Admin. Code;
- psychotherapy for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention;
- psychotherapy provided in a recipient's home;
- self-referrals ("self-referral" means that a provider refers a recipient to an agency in which the provider has a direct financial interest, or to himself or herself acting as a practitioner in private practice; and
- court appearances except when necessary to defend against commitment.

As specified in HSS 107.13 (3)(d), Wis. Admin. Code, the following services are not WMAP-covered AODA clinic services:

- collateral interviews and consultations with persons other than the recipient's immediate family, except as provided in HSS 107.06 (4)(c), Wis. Admin. Code;
- court appearances except when necessary to defend against commitment; and
- detoxification provided in a social setting, as described in HSS 61.58, Wis. Admin. Code.

As specified in HSS 107.03, Wis. Admin. Code, the following services are not WMAP-covered services:

- psychiatric examinations and evaluations ordered by the court, following the conviction of a crime, pursuant to s. 972.15, Wis. Stats;
- services to a recipient who is an inmate of a public institution or services to a person 21 to 64 years of age who is a resident of an institution for mental diseases (IMD), unless the recipient is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, unless the recipient is on convalescent leave from an IMD; and
- consultations between or among providers. Direct recipient contact for the purpose of performing an evaluation that forms the basis of a consultation is covered as noted in Section II-C of this handbook.

G. NONCOVERED SERVICES AND RELATED LIMITATIONS (continued)

As specified in HSS 107.13(1)(f), Wis. Admin. Code, the following services are not WMAP-covered outpatient psychotherapy or AODA professional services when provided to hospital inpatients:

- services provided to a hospital inpatient by a master's level psychotherapist or AODA counselor are not separately reimbursable as mental health/AODA professional services when billed by an outpatient psychotherapy clinic; and
- group therapy and medication management are not separately reimbursable as professional mental health or AODA services when provided to a hospital inpatient.

As specified in HSS 107.13(2)(c), Wis. Admin. Code, outpatient psychotherapy services are not reimbursed if the recipient is receiving WMAP-covered community support program (CSP) services.